CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND I LAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED 06/16/2011		
			B. WIN			00/10/2	1011
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		1	ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	OOD AT HOBART				T MARY CIRCLE RT, IN46342		
		THE OF PERSONS			,		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		(X5)
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	REGULATORT OR	LSC IDENTIFFING INFORMATION)	+	IAU			DATE
R0000							
	This visit was for	r the Investigation of	R	0000			
	Complaint IN000	_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Complaint Invoc	070734.					
	Complaint IN000	090754 - Substantiated.					
	•	deficiencies related to the					
	allegations are ci	ited at R0116, R0241, and					
	R0349.						
	10313.						
	Survey date: Jun	e 16, 2011					
	Survey date: value 10, 2011						
	Facility number: 002627						
	Provider number						
	AIM number: N/						
	Survey team:						
	Kathleen (Kitty)	Vargas, RN, TC					
	Lara Richards, R						
	2010 11101101 05, 11						
	Census bed type:						
	Residential: 110						
	Total: 110						
	10141.						
	Census payor typ	ne.					
	Other: 110	,					
	Total: 110						
	101.110						
	Sample: 5						
	Sample. 3						
	These state finding	ngs are cited in					
	accordance with	_					
	accordance with	T10 IAC 10.2.					
	Quality raviaw o	ompleted 6/21/11 by					
	Quality leview Co	Ompiciou 0/21/11 by					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNAT					TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CRTJ11

Facility ID:

002627

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI OO COMPLE					
			A. BUILDING 06/16/20				
			B. WING	TDEET A	DDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF F	PROVIDER OR SUPPLIER				MARY CIRCLE		
BRENTW	OOD AT HOBART				T, IN46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	1	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	Jennie Bartelt, R	LSC IDENTIFYING INFORMATION)	17	AG	DEFICIENCY)		DATE
R0116	(a) Each facility sh written and implem prospective employshall be made for p	all have specific procedures nented for the screening of yees. Appropriate inquiries prospective employees. The					
	considers reference accordance with IC Based on record refacility failed to it policy related to the checks for 4 of 4 reviewed. (Resident Care As	review and interview, the mplement the personnel the lack of reference employee records ent Care Assistant #1, sistant #2, Resident Care Resident Care Assistant	R011	R0116 Plan of Correction is not to a construed as an admission of agreement with the findings of conclusions in the Statement Deficiencies, or the proposed administrative penalty (with a correct) on the community. It is submitted as confirmation our ongoing efforts to comply statutory and regulatory requirements. In this document have outlined specific actions.		r d f tht to ther, of vith	07/01/2011
	6/16/11 at 1:15 p. employee files w	t Care Assistant) #1 was There were no reference			response to each allegation or finding. We have not presented contrary factual or legal arguments, nor have we identimitigating factors. We remain committed to the delivery of que health care services and will continue to make changes and improvement to satisfy that objective.	ified	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (2			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED	
			B. WING 06/16/2011			06/16/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIEF	R			T MARY CIRCLE	
BRENTV	VOOD AT HOBART				RT, IN46342	
				<u> </u>		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	1	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	employee's file.				Date Day P	
					R 116 Personnel - Noncomplia	nce
	2. RCA #2 was	hired on 1/7/11. There			What corrective action(s) will b	10
	were no reference	ee checks available for			accomplished for those employe	
	review in the em	plovee's file.			files found to have been affected	•
		r - J			the alleged deficient practice?	
	3 RCA #3 Was	hired on 2/16/11. There			· Employee #1, #2, #3, #4	
		the checks available for			reference check completed by the	he
					BOD on June 20th, 2011	
	review in the em	ployee's file.				
					How will the facility identify of	
	4. RCA #4 was	hired on 4/12/11. There			residents with the potential to b	e
	were no reference	e checks available for			affected by the same alleged	
	review in the employee's file.				deficient practice and what corrective action will be taken?	
					corrective action will be taken:	
	The policy titled	, "Hiring Process			· The Business Office Dir	ector
	1 ^ -	provided by the Resident			and/or designee will audit	
	1	1 6/16/11 at 2:05 p.m. She			Employee files for reference ch	ecks
	1	_			by 7/1/2011 if any are found to	be
	1	licy was current. The			out of compliance they will be	
	1 -	that reference checks and			corrected by 7/1/11.	
		o be verified prior to the				
	start of employn	nent.			What measures will be put in pl	
					or what systemic changes will t facility make to ensure the alleg	
	Interview with the	ne Business Office			deficient practice does not recu	' I
	Manager on 6/16	6/11 at 2:15 p.m. indicated			· Department heads who	, ,
	1	ecks were required to be			participate in the hiring process	have
	obtained for all prospective employees, prior to the start of employment. She also indicated there were no reference checks obtained for RCA #1, RCA #2, RCA #3 and RCA #4. She indicated two reference				been educated by The Executiv	•
					Director 6/20/11 regarding the	
					community policy and are	
					responsible for completing two	
					reference checks on new hires	prior
					to offering a position	
	checks should ha	ave been obtained for the				
	four employees.				How will the corrective actions	ha
					monitored to ensure the deficien	I
	This state finding	g relates to Complaint			monnorea to ensure the deficter	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED			
			A. BUILDING B. WING		06/16/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIRCLE HOBART, IN46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
R0241	(e) The administration provision of reside as ordered by the shall be supervise premises or on ca (1) Medication shallicensed nursing predication aides. Based on record facility failed to administered as orelated to the admittance the recommensure of the shall be supervised premises or on ca (1) Medication shallicensed nursing predication aides. Based on record facility failed to administered as orelated to the admittance the recommensure of the shall be supervised to the shall be supervised as the shall be supervised to the sha	tion of medications and the ntial nursing care shall be resident's physician and d by a licensed nurse on the ll as follows: all be administered by ersonnel or qualified review and interview, the ensure medications were ordered by the physician, ministration of Aricept at mended dosage, for 1 of 4 ed who have medications facility staff, in a sample B)	R0241	practice will not recur, i.e., who quality assurance programs with put in place? The business office dire and/ or designee will audit new employee files within 24 hours hire to ensure compliance Audits will be reviewed quarterly QA meetings for compliance for a minimum of t quarters. The regional team will monitor for compliance on rand visits to the community and dut the annual comprehensive review By what date will these systemic changes be implemented? T/1/11 R 241 Health Services offer What corrective action(s) who accomplished for those resident to have been affected the alleged deficient practice. Resident #B moved out of community on 5/27/11 How the facility identify other resident the potential to be affect by the same alleged deficient practice and what corrective action will be taken? RCD	at at at a labe be better wood of at at a wood on the sew. c 07/08/2011 ill be dents by e?		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 06/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1420 ST MARY CIRCLE **BRENTWOOD AT HOBART** HOBART, IN46342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE or designee will audit physician orders and MARs for residents. If The record for Resident #B was reviewed any discrepancies are on 6/16/11 at 11:20 a.m. The resident had discovered, the residents will be diagnoses that included, but were not assessed for adverse reactions and their physicians and families limited to, Alzheimer's disorder, will be notified by 7/8/11 What dementia, confusion and psychiatric fear. measures will be put in place or The resident's admission orders, dated what systemic changes will the 3/25/11, indicated the resident was to facility make to ensure the receive Aricept (a medication for the alleged deficient practice does not recur? · Community treatment of Alzheimer's Disease) 5 mg licensed nurses and qualified (milligrams) by mouth twice daily. medication aides will be reeducated on the community The form titled, "Healthcare Provider policy regarding medication administration / errors by the Communication Form," was dated resident care director on 7/8/11. 4/15/11. It was a form used by the facility Community licensed nurses and to communicate with the physician via qualified medication aides will be fax. The section of the form titled skill tested to demonstrate competency by the Resident care "Concern reason for visit/communication" director and/ or designee by indicated "Possible med. (medication) 7/8/11 How will the corrective error. MAR (medication administration actions be monitored to ensure record) read Aricept 5 mg po (by mouth) the deficient practice will not BID ((twice daily) Pharmacy stating sent recur, i.e., what quality assurance programs will be put in place? Aricept 10 mg PO Daily. Pharmacy The RCD and/ or designee will changed dose without notifying staff. complete random audits of Unaware if true med error no longer have physician orders / MARs monthly, on 10% of our community empty card. Resident has no complaint of population. · Audits will be anything. MAR changed to match reviewed at quarterly QA directions on medication card." Under the meetings for compliance for a section titled "Healthcare provider minimum of two quarters. · The regional team will monitor for findings and recommendations," the compliance on random visits to physician indicated, "should receive the community and during the Aricept 10 mg po daily" the physician's annual comprehensive process name was written and it was dated review. By what date will these systemic changes be 4/18/11.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CRTJ11

Facility ID:

002627

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	06/16/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
NAME OF	PROVIDER OR SUPPLIE	R		1	T MARY CIRCLE	
BRENTV	VOOD AT HOBART			1	RT, IN46342	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
					implemented? · 7/3/11	
		ervice Notes dated				
	_	4/26/11 indicated no				
		of a incorrect dose of				
		lministered. There was no				
	documentation t	o indicate the lack of				
	adverse side effe	ects of the incorrect dose				
	of Aricept.					
		'Event Management				
	Report- Medicat	tion Occurrence" was				
	provided by the	Resident Care Director on				
	6/16/11 at 11:15	a.m. She indicated a				
	medication adm	inistration error had				
	occurred with R	esident #B. The form				
	indicated, "MAI	R read Aricept 5 mg PO				
	BID. Pharmacy	stating they sent Aricept				
	10 mg PO Daily	so staff was giving				
	Aricept 10 mg P					
	The "2010 Nurs	ing Spectrum Drug				
	Handbook" indi	cated the indications and				
	dosages for Aric	ept as follows:				
	1	erate Alzheimer's				
		: Initially, 5 mg po daily				
		r 4 to 6 weeks, may				
	increase dosage to 10 mg.					
	For severe Alzheimer's Disease, Adults: 10 mg po daily.					
	10 mg po duny.					
	Interview with the	he Resident Care Director				
		:15 p.m. indicated the				
		rovided Aricept 10 mg				
upon the resident's admission to the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND TEXT OF CONNECTION IDENTIFICATION NOMBER.			A. BUILDING 00			COMPLETED 06/16/2011	
			B. WIN			00/10/2	2011
NAME OF I	PROVIDER OR SUPPLIER	3		1	DDRESS, CITY, STATE, ZIP CODE		
	ACOD AT LICEART			1	MARY CIRCLE		
BRENIV	VOOD AT HOBART			HOBAR	T, IN46342		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
	1	11. She indicated the					
		s labels the medication					
		tion name and the dose of					
		She indicated the wrong					
		ept was administered by					
	1	twice daily from 3/25/11					
		ne resident received 10 mg					
	1	daily for a total of 20 mg					
	per day instead of	of the physician's ordered					
	dose of 5 mg of	Aricept twice daily for a					
	total of 10 mg per day. She indicated the						
	error was not noted until family was						
	called to obtain another prescription of						
	Aricept and indi	cated it was not time for a					
	medication refill	. She indicated staff had					
	not identified the	e medication error despite					
	the dose on the r	nedication package not					
	matching the ph	ysician's order. She					
		or was not discovered					
	timely by facility	y staff.					
		,					
	Continued interv	view with the Resident					
		6/16/11 at 12:15 p.m.					
	indicated there v	_					
		n the Service Notes of the					
		e resident for adverse side					
		medication error was					
		ated there should be					
		of the assessment of the					
		erse side effects of the					
	medication error						
	This state finding	a relates to Commisint					
		g relates to Complaint					
	IN00090754.						

002627

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 06/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1420 ST MARY CIRCLE **BRENTWOOD AT HOBART** HOBART, IN46342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (a) The facility must maintain clinical records R0349 on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. R0349 R-349 Clinical records 07/08/2011 Based on record review and interview, the noncompliance What facility failed to ensure the clinical record corrective action(s) will be for each resident was complete and accomplished for those residents accurate related to the lack of found to have been affected by documentation of a resident's response to the alleged deficient practice? · Resident #B moved out of a medication error for 1 of 5 resident community on 5/27/11 How will records reviewed in a sample of 5. the facility identify other residents (Resident #B) with the potential to be affected by the same alleged deficient practice and what corrective Findings include: action will be taken? · RCD and/ or designee will audit service The record for Resident #B was reviewed notes for any resident who has on 6/16/11 at 11:20 a.m. The resident had had a suspected or confirmed medication errors to ensure that diagnoses that included, but were not the event is properly documented limited to, Alzheimer's disorder, by 7/8/11 and ongoing What dementia, confusion and psychiatric fear. measures will be put in place or The resident's admission orders, dated what systemic changes will the 3/25/11, indicated the resident was to facility make to ensure the alleged deficient practice does receive Aricept (a medication for the not recur? · Community licensed treatment of Alzheimer's Disease) 5 mg nurses and qualified medication (milligrams) by mouth twice daily. aides will be reeducated on the community policy regarding documentation of medication The form titled, "Healthcare Provider errors by _7/8/11 How will the Communication Form," was dated

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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002627

If continuation sheet

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B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5)				l		06/16/2	2011
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)				1420 S	T MARY CIRCLE		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLE	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
4/15/11. It was a form used by the facility to communicate with the physician via fax. The section of the form titled "Concern reason for visit/communication" indicated "Possible med. (medication) error. MAR (medication administration record) read Aricept 5 mg po (by mouth) BID ((twice daily) Pharmacy stating sent Aricept 10 mg PO Daily. Pharmacy changed dose without notifying staff. Unaware if true med error no longer have empty card. Resident has no complaint of anything. MAR changed to match directions on medication card. "Under the section titled "Healthcare provider findings and recommendations," the physician indicated, "should receive Aricept 10 mg po daily" the physician's name was written and it was dated 4/18/11. Review of the Service Notes dated 3/25/11 through 4/26/11 indicated no documentation to indicate the resident's response to the incorrect dose of Aricept. There was no documentation if the resident had the presence or the absence of adverse side effects from the incorrect dose of Aricept. The form titled "Event Management Report- Medication Occurrence" was		to communicate fax. The section "Concern reason indicated "Possible error. MAR (medicated) read Arice BID ((twice daily Aricept 10 mg Pochanged dose with Unaware if true is empty card. Resist anything. MAR of directions on mesection titled "Hofindings and record physician indicated Aricept 10 mg pochange was written 4/18/11. Review of the Section 3/25/11 through documentation of Aricept being addocumentation to response to the interest and the position of adverse side edose of Aricept. The form titled "The form titled"	with the physician via of the form titled for visit/communication" ble med. (medication) dication administration tept 5 mg po (by mouth) y) Pharmacy stating sent O Daily. Pharmacy thout notifying staff. med error no longer have dent has no complaint of changed to match dication card." Under the tealthcare provider ommendations," the ted, "should receive to daily" the physician's and it was dated 4/26/11 indicated no of a incorrect dose of ministered. There was no to indicate the resident's factorrect dose of Aricept. cumentation if the presence or the absence ffects from the incorrect		ensure the deficient prace not recur, i.e., what quality assurance programs will place? The RCD and/designee will complete reaudits of resident services monthly, on 10% of our community population. Will be reviewed at quarter meetings for compliance minimum of two quarters regional team will monito compliance on random with the community and during annual comprehensive preview. By what date will systemic changes be	tice will ty be put in or undom notes Audits erly QA for a . The r for sits to g the rocess	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			1	COMPLETED 6/16/2011	
			B. WIN			06/16/2	011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
DDENITA	VOOD AT HOBART			1	T MARY CIRCLE RT, IN46342			
					(1, IN40342			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710		Resident Care Director on	<u> </u>	mo	·		DATE	
	^	a.m. She indicated a						
		nistration error had						
		esident #B. The form						
		read Aricept 5 mg PO						
	· ·	stating they sent Aricept						
	1	so staff was giving						
	Aricept 10 mg P(
	7 tricept 10 mg 1	O DID.						
	The "2010 Nursi	ng Spectrum Drug						
		eated the indications and						
	dosages for Arice							
	For mild to mode	-						
		Initially, 5 mg po daily						
		4 to 6 weeks, may						
	increase dosage t	• •						
		imer's Disease, Adults:						
	10 mg po daily.	mici s Discuse, riduits.						
	10 mg po dany.							
	Interview with th	ne Resident Care Director						
		15 p.m. indicated the						
		ovided Aricept 10 mg						
	1	t's admission to the						
	1 ^	1. She indicated the						
	1 *	s labels the medication						
	^ -	ion name and the dose of						
		She indicated the wrong						
		pt was administered by						
		twice daily from 3/25/11						
	l *	e resident received 10 mg						
		daily for a total of 20 mg						
		f the physician's ordered						
	^	Aricept twice daily for a						
	l -	er day. She indicated the						
total of 10 mg per day. She muleated the								

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 06/16/2	LETED	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART			STREET A 1420 S	ADDRESS, CITY, STATE, ZIP CODE T MARY CIRCLE RT, IN46342	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
IAG	error was not not called to obtain a Aricept and indic medication refill. Continued interv Care Director on indicated there we documentation in assessment of the effects after the reference.	ed until family was nother prescription of cated it was not time for a iew with the Resident 6/16/11 at 12:15 p.m.	IAG	DEFICIENCY		DATE
	documentation or resident for advermedication error should have documentation absence of adver	f the assessment of the rse side effects of the She indicated staff amented the presence or				